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Nos. 95-1858, 96-110

In The
Supreme Court of the United States
October Term, 1996

DENNIS C. VACCO, *et al.*
Petitioners,

v.

TIMOTHY E. QUILL, M.D., *et al.*
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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STATE OF WASHINGTON, *at ano.*,
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BRIEF OF AGUDATH ISRAEL OF AMERICA AS AMICUS CURIAE IN SUPPORT OF THE PETITIONERS

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INTEREST OF THE AMICUS CURIAE

Agudath Israel of America, a national grassroots Orthodox Jewish movement founded in 1922, is deeply concerned about the rulings below and the broader

implications they hold for the future, and respectfully submits this brief as *amicus curiae* in support of the respective petitioners.

Informed by classical Jewish tradition which teaches that all human life is sacred, and possessed of the firm view that laws and judicial rulings that undermine the sanctity of human life send a message that is profoundly dangerous for all of society, Agudath Israel speaks out frequently, in a variety of legal and policy settings, on a broad array of issues that arise at the onset and conclusion of the human life cycle. In this court, for example, Agudath Israel has submitted briefs as *amicus curiae* in the abortion rights cases of *Webster* v. *Reproductive Health Services* (decision reported at 492 U.S. 490 (1989)) and *Planned Parenthood of Southeastern Pennsylvania* v. *Casey* (decision reported at 505 U.S. 833 (1992)); and -- more directly relevant to the issues involved in the instant case -- in the "right to die" case of *Cruzan* v. *Director, Missouri Department of Health* (decision reported at 497 U.S. 261 (1990)).

Agudath Israel's interest in the issue of physician assisted suicide is especially keen. It is a basic principle of Jewish law and ethics that "[m]an does not possess absolute title to his life or body." J.D. Bleich, *The Quinlan Case: A Jewish Perspective*, reprinted in *Jewish Bioethics* 266, 270 (Hebrew Publishing Co. 1979). Agudath Israel believes that recognition of that teaching, as expressed in the historical disapprobation of suicide and euthanasia, has served as one of the pillars of civilized societies throughout

the generations. That pillar is now in peril.*

It is yet another principle of Jewish law and ethics that a doctor's role is to provide healing, not to hasten death. *See* I. Jakobovits, *Regarding the Law Whether it is Permitted to Hasten the End of a Terminal Patient in Great Pain*, 31 *Ha-pardes* 29 (1956). Doctors who assist in the commission of suicide, even when motivated by the most humane of concerns, exceed the bounds of their own Hippocratic mandate and undermine public confidence in the medical profession. Anthropologist Margaret Mead -- herself a supporter of certain forms of euthanasia, so long as they are under lay initiative and control -- has urged that "the medical profession should not be compromised by participation" in euthanasia; "[t]he physician's dedication to the saving of life is of incalculable value to humanity and must be protected from repeated efforts to involve the doctor in lethal activities." M. Mead, *From Black and White Magic to Modern Medicine*, 22 Proceedings of the Rudolf Virchow Medical Society 131 (1965). Agudath Israel views with considerable alarm the transformation of the physician's calling envisioned by the decisions below.

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* To the extent the Ninth Circuit below meant to suggest that Judaism "views suicide with equanimity or acceptance," *Compassion in Dying* v. *Washington*, 79 F.3d 790, 807 n.24 (1996) (*see also id.* at 808 n.25), the court was simply wrong. The general rule is that suicide and its facilitation are strictly forbidden under Jewish law, no matter how unbearable life may have become. *See generally* F. Rosner, *Modern Medicine and Jewish Ethics*, 225-39 (Ktav Publishing House, Yeshiva University Press 1986).

Moreover, as representatives of a people whose numbers were decimated little more than half-a-century ago by a society that "progressed" from its "enlightened" practices of "mercy killing" to the mass slaughter of millions of human beings deemed physically or racially "inferior," Agudath Israel is particularly sensitive to the legal assignment of diminished levels of life protection based on diminished levels of life "quality". The decisions below reflect this dangerous trend away from the recognition of life's inherent sanctity and present a stark challenge to our nation's social morals.

Agudath Israel submits this brief upon the consent of all parties.

ARGUMENT

The two federal circuit courts below -- the Ninth Circuit in *Compassion in Dying* v. *State of Washington*, 79 F.3d 790 (9th Cir., March 6, 1996) (*en banc*), *request for rehearing denied,* 85 F.3d 1440 (9th Cir. June 12, 1996); and the Second Circuit in *Quill* v. *Vacco*, 80 F.3d 716 (2d Cir., April 2, 1996) -- found as-applied constitutional infirmities in Washington and New York state statutes that make it a crime to "aid" another individual in committing or attempting to commit suicide. The two rulings reached similar (though not identical) bottom lines, but arrived at their destinations through different constitutional routes.

The Ninth Circuit found a due process "liberty interest in choosing the time and manner of one's death," 79 F.3d at 798; and determined, in the context of "competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors," that such due process liberty interest outweighed any countervailing interest asserted by the state. *Id.* at 838.

The Second Circuit, in contrast, relied on the equal protection clause in holding that physicians are constitutionally permitted to "prescribe drugs to be self-administered by mentally competent adults who seek to end their lives during the final stages of a terminal illness." 80 F.3d at 718. Such persons, reasoned the court, are "similarly circumstanced" to final-stage terminally ill patients who enjoy the statutory and common law right to hasten their death by authorizing termination of life support, *id.* at 729; and, the court concluded, there is no legitimate state interest rationally served by distinguishing between the two categories. *Id.* at 730-31.

Both grounds of decision, Agudath Israel submits, are wrong. The better of the legal argument, we believe, is with the dissenting judges in the Ninth Circuit *en banc* decision (79 F.3d at 839 (Beezer, J.), 857 (Fernandez, J.) & 857 (Kleinfeld, J.)); with the dissenting judges in the Ninth Circuit's subsequent rejection of a request to have the *en banc* decision reheard by the full circuit court (85 F.3d at 1440 (O'Scannlain, J.), 1446 (Trott, J.)); with the Ninth Circuit's earlier panel in *Compassion in Dying* v. *State of Washington*, 49 F.3d 585 (9th Cir. 1995); with the district court in *Quill* v. *Koppell*, 870 F.Supp. 78 (S.D.N.Y. 1994); and with the Michigan Supreme Court in *People* v. *Kevorkian*, 447 Mich. 436 (1994), *cert. denied* 115 S. Ct. 1795 (1995). With respect to the due process argument, we share the view of these judges and courts that this Court's broad dictum in *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833, 851 (1992) -- identifying "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life" as being "at the heart of liberty" -- does not elevate assisted suicide to the status of a constitutionally protected right. With respect to the equal protection argument, we contend, as have many courts, legislative and executive bodies, medical associations and bioethical experts, that there is a sound basis of legal distinction between what one commentator has termed "letting the patient die" and "making the patient die" S.L. Carter, *The Culture of Disbelief* 236 (Basic Books 1993) -- though we also believe there can and should be legal restrictions on the authority of patients and their surrogates even to decline life support.

Mindful of the admonition that "[a]n *amicus* brief which does not serve [the purpose of bringing relevant

matter to the attention of the Court that has not already been brought to its attention by the parties] simply burdens the staff and facilities of the Court and its filing is not favored," Rule 37.1, *Rules of the Supreme Court of the United States* (1990), we will not belabor the reasons we think the constitution does not create any right to assisted suicide; they are well articulated in the decisions and opinions cited in the preceding paragraph, and are sure to be further developed by the petitioners themselves.

The focus of our argument, therefore, will be not on why we think the decisions below are *bad* law, but why we think they are *dangerous* law. The legalization of assisted suicide, even in the narrow contexts addressed by the decisions below, has the potential to lead to tragic abuse (Point I, *infra)*. Moreover, the Ninth and Second Circuit rulings portend a far-reaching relaxation of laws against assisted suicide and euthanasia, in contexts very different than those in which the two cases arose (Point II, *infra*). Perhaps most troubling, the two courts' determination that lives of diminished "quality" are entitled to diminished constitutional protection ignores some important lessons of 20th century history that deserve careful consideration (Point III, *infra)*.

I.

LEGALIZING ASSISTED SUICIDE, IN ANY FORM, COULD LEAD TO TRAGIC ABUSE

Agudath Israel takes both moral and legal exception to the notion that a person enjoys unfettered personal autonomy to decide that his life is no longer worth living. Society has the right to compel citizens to submit to

vaccination, *Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905); to insist that a child receive life-sustaining treatment even over the religiously motivated opposition of his parents, *Jeovahs Witnesses* v. *King County Hospital Unit*, 390 U.S. 598 (1968); to prevent a pregnant woman in her second trimester from receiving an abortion in an unlicensed facility, *Roe* v. *Wade*, 410 U.S. 113, 163 (1973); to restrict the handling of poisonous snakes and drinking poisonous substances as part of a religious ceremony, *State ex rel. Swann* v. *Pack*, 527 S.W. 2d 99 (Tenn. 1975), *cert denied* 424 U.S. 954 (1976); to enact laws designed to protect users of highways "even against the consequences of their own action," *Bisenius* v. *Karns*, 165 N.W. 2d 377, 382, *appeal dismissed* 365 U.S. 709 (1969).

There are particularly strong reasons to reject the view that the generally accepted doctrine of personal autonomy in medical decision making should allow patients to enlist their doctors' help in committing suicide. The potential abuses of legalizing assisted suicide have been well catalogued by a host of legal and medical observers. For example, in its landmark report opposing assisted suicide, the 24-member New York State Task Force on Life and the Law, speaking unanimously, noted the following concerns: the pressures patients would feel, from their doctors and families, to opt for suicide; the inherent inequalities of our health care delivery systems which tend to discriminate against the poor, the handicapped and the elderly; the psychological vulnerability of the severely ill; the risk of misdiagnosis of the patient's condition; the likelihood in many cases that adequate treatment of pain and depression would dissuade the patient from seeking death. New York State Task Force on Life and the Law, *When Death is*

Sought: Assisted Suicide and Euthanasia in the Medical Context 121-34 (1994). Indeed, these risk factors will often raise serious doubts about whether a patient's request for help in committing suicide is truly an expression of the patient's autonomous will.

We concur with the Task Force's observation (Report at 121) that, "as a society, we have better ways to give people greater control and relief from suffering than by making it easier for patients to commit suicide or to obtain a lethal injection."

II.

THE DECISIONS BELOW, IF AFFIRMED, ARE LIKELY TO LEAD TO A BROAD EXPANSION OF THE RIGHT TO ASSISTED SUICIDE AND EUTHANASIA

On their faces, the Ninth and Second Circuit decisions are extremely narrow. They apply only to fully competent terminally ill patients (or, in the case of *Quill*, patients in the "final stages" of terminal illness) who have clearly expressed their desire to commit suicide, and who seek only such assistance from their physicians as is necessary for them to self-administer a lethal dosage of drugs. However, the *language* of the decisions (especially the expansive statements of the Ninth Circuit), and their *reasoning* (especially the equal protection analysis of the Second Circuit), could well result in the expansion of the right to assisted suicide and euthanasia far beyond the narrow confines in which the cases arose. The Court would do well to ponder the ultimate destination of the paths the Ninth and Second Circuits would have the constitution embark.

1. The Ninth Circuit's Candid Acknowledgments

The three patient-plaintiffs in *Compassion in Dying* (in this Court as *Glucksberg*) were mentally competent, whose illnesses were deemed "terminal" because their doctors had concluded they were irreversible and would likely cause death within a relatively short time, and who clearly articulated their desire to have their doctors furnish them with a lethal dosage of medication for their own self-administration. The Ninth Circuit, however, candidly acknowledged that its ruling in their favor was not so narrowly limited.

For one thing, said the court, it is not only doctors whose prescriptive services are protected by the constitutional right to assisted suicide, but also "those whose services are essential to help the terminally ill patient obtain and take [the lethal prescription] and who act under the supervision or direction of a physician... That includes the pharmacist who fills the prescription; the health care worker who facilitates the process; the family member or loved one who opens the bottle, places the pills in the patient's hand, advises him how many pills to take, and provides the necessary tea, water or other liquids; or the persons who help the patient to his death bed and provide the love and comfort so essential to a peaceful death." 79 F.3d at 838 n.140. In addition, the court noted that its holding encompassed the decisions of persons who are terminally ill not only as that term is colloquially understood, but also as it is statutorily defined -- in Washington Sate, for example, persons who are in an irreversible coma or a persistent vegetative state, regardless of their life expectancy. 79 F.3d at 831.

Significant though these acknowledgements are, it is in two other respects that the Ninth Circuit's expansive articulation of its position is especially noteworthy: (a) the court's view on physician-administered poison; and (b) the court's recognition of the authority of surrogate decision makers.

(a) While the court expressly left for "future cases" the issue of a doctor's right to inject a lethal dosage into a patient incapable of self-administering the poison, it candidly indicated its view that this too would be constitutionally protected:

> "We do not dispute the dissent's contention that the prescription of lethal medication by physicians for use by terminally ill patients who wish to die does not constitute a clear point of demarcation between permissible and impermissible medical conduct. We agree that it may be difficult to make a principled distinction between physician-assisted suicide and the provision to terminally ill patients of other forms of life-ending medical assistance, such as the administration of drugs by a physician. We recognize that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only way the patient may be able to receive them... We would be less than candid... if we did not acknowledge that for present purposes we view the critical line in right-to-die cases as the one between the voluntary and involuntary termination of an individual's life. In the first case — volitional death — the physician is aiding or assisting a patient who

> wishes to exercise a liberty interest, and in the other — involuntary death — another person acting on his own behalf, or, in some instances society's, is determining that an individual's life should no longer continue. We consider it less important who administers the medication than who determines the medication than who determines whether the terminally ill person's life shall end." 79 F.3d at 831-32 (footnotes omitted).

(b) The court emphasized that the constitutional demarcation it would draw between "volitional death" and "involuntary death" was not intended to imply that the right to request assistance in committing suicide is necessarily personal to the patient himself. "[W]e should make it clear," wrote the court, "that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself." 79 F.3d at 832 n.120. (Indeed, noted the court, under certain circumstances, Washington law also regards the decisions of a legal guardian as the decision of the patient himself, 79 F.3d at 818 (citing, *inter alia*, *In re Guardianship of Grant*, 747 P.2d 445 (Wash. 1987), in which the Washington Supreme Court authorized a legal guardian to "make a good-faith determination of whether the withholding of life sustaining treatment would serve the incompetent patient's best interests" where the patient's own wishes cannot be ascertained, 747 P.2d at 457). Presumably, therefore, just as a duly appointed surrogate decision maker could request a lethal prescription on a patient's behalf, so too could a legal guardian in cases where his decisions are treated as the patient's own.)

It should be readily apparent that the Ninth Circuit's

caveat about the authority of surrogate decision makers undermines considerably its bright line distinction between "volitional death" and "involuntary death". Professor Tribe has summarized the three types of situations in which surrogate decision makers have exercised "substituted judgment" on behalf of incompetent patients:

> "There are basically three approaches courts have taken to decisionmaking in treatment decisions for incompetent patients. First, if the patient had when competent stated what decision she would have wanted made in this situation, those wishes tend to be deemed decisive. Second, where there is no direct evidence of the patient's preferences, if there is a relative or a friend who was close enough to the patient to be able to surmise how she would have decided, this relative or friend may be allowed to choose in the name of the patient. Third, if there is no basis for deciding what the patient would have decided, a decision is made according to what would be in the patient's 'best interests', as defined by the court, by the patient's family, or by a court-appointed guardian."

L. Tribe, *American Constitutional Law*, § 15-11 at 1368-69 (2d Ed. 1988) (footnotes omitted). As Professor Tribe points out, however, "*[a]ll three forms of 'substituted judgment' are at best imperfect ways to effectuate the patient's right of self-determination*. No matter how much evidence there is of subjective intent, how well the guardian knew the patient, and how well-intentioned the patient's guardian, family, and physician may be, *there will always*

be some residual doubt that the decision made in fact expresses what the patient would have wanted done." Id. at 1369 (emphasis added; footnote omitted).

In sum, the Ninth Circuit would apparently extend the constitutional right of assisted suicide to cases involving a surrogate decision maker's request, based on his admittedly imperfect knowledge of an incapacitated terminal patient's wishes, or perhaps even on his own assessment of the patient's best interests, to have a doctor *kill the patient*. This brings to mind a prescient passage elsewhere in Professor Tribe's treatise:

> "As courts become more sympathetic to arguments that persons have a right to die with dignity and that the state interest in the preservation of life may sometimes be subordinated to an individual's right to die, there is a possibility that doctrines which are intended to facilitate the exercise of this right will be exploited, either intentionally or unwittingly, to practice the most terrible discrimination against handicapped persons who require medical treatment to stay alive: judgments that their disabilities are such that persons afflicted with them would be better off dead and thus should be 'allowed' to die. The most pernicious discriminatory bias against the disabled that one can imagine -- the desire of families or others to dispose of handicapped persons whom they simply consider undesirable -- might be effectively disguised behind their requests, made in the name of the disabled's right to die, that

> medical treatment be withheld from the disabled. The right to die, in other words, may offer a convenient pretext for profoundly discriminatory decisionmaking."

L. Tribe, *supra,* § 16-31 at 1598-99 (footnotes omitted).

2. Implications of the Second Circuit's Equal Protection Analysis

The Second Circuit took pains to give its ruling a more moderate veneer than that of its sister court. The court expressly rejected any substantive due process right to assisted suicide, 80 F.3d at 723-25; determined that the equal protection claim would be judged under the less exacting standard of rational basis scrutiny, *id.* at 727; intimated that the right to assisted suicide would not authorize a physician to inject a lethal dosage into a patient incapable of self-administering the dosage, *id* at 730 n.3; said nothing about the right of a surrogate decision maker to request suicide assistance on behalf of an incapacitated patient; and limited the terms of its holding to patients in the final stages of terminal illness, *id.* at 731.

In fact, however, it may well be that the Second Circuit's ruling creates an even more expansive right to assisted suicide than does the Ninth Circuit's. That is because of a basic difference between the respective judicial inquiries under the due process and equal protection clauses.

As the Ninth Circuit pointed out, the due process constitutional claim of a patient seeking suicide assistance will be determined, like all substantive due process claims,

by weighing the strength of the various competing interests present in any given circumstance. The court's calibration of those competing interests led it to its bottom line determination: "The liberty interest at issue here...in the case of the terminally ill, is at its peak. Conversely, the state interests, while equally important in the abstract, are for the most part at a low point here." 79 F.3d at 837. While Agudath Israel believes, as elaborated *infra,* that the Ninth Circuit incorrectly undervalued the state's interest in preserving the life of even terminally ill persons there is at least some room for argument that the due process balancing framework will enable courts, in cases involving non-terminal patients where the balance of competing interests tips in favor of the state, to draw the line: "So far down the slope, but no farther." The equal protection framework embraced by the Second Circuit, in contrast, would appear to include no such line-drawing braking mechanism.

The relevant equal protection inquiry here is *not* how strong the state's interest is in preserving life in any given context, but whether treating "similarly circumstanced" persons differently is rationally related to a legitimate state interest. As the Court stated in *Hooper* v. *Bernalillo County Assessor*, 472 U.S. 612 (1985): "When a state distributes benefits unequally, *the distinctions it makes* are subject to scrutiny under the Equal Protection Clause of the Fourteenth Amendment. Generally, a law will survive that scrutiny if *the distinction* rationally furthers a legitimate state purpose." *Id.* at 618 (footnote omitted; emphasis added). Accordingly, once one accepts the Second Circuit's conclusion that a patient who seeks termination of life support and a patient who seeks poison are "similarly circumstanced persons" who must be treated identically

unless the state can demonstrate that treating them differently rationally advances a legitimate state interest, 80 F.3d at 729; and once one accepts the court's additional conclusion that no such rational basis of distinction exists when the two persons are in the final stages of terminal illness, *id.* at 730-31 -- there is no readily apparent logical way of drawing lines anywhere along the slope.

In reaching its holding that the prohibition against assisted suicide, as applied to final-stage terminally ill patients, violates the equal protection clause, the Second Circuit posed a series of dramatic questions, and an equally dramatic answer:

> "But what interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes... And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient's 'right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life' [citation omitted], when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state in preserving life compels the answer to these questions: 'None.'" 80 F.3d at 729-30.

The questions are indeed dramatic, and so is the response -- but they are also highly misleading. For they imply that the equal protection analysis would be different in cases where the state's interest in preserving life would

be stronger than the Second Circuit deems it to be at the final stages of terminal illness. In fact, however, since the relevant inquiry is not whether the state has a rational basis to preserve life, but whether it has a rational basis to *distinguish* between patients who refuse life support and patients who seek the means to commit suicide, it should make no equal protection difference whatsoever how far along the patient's terminal illness has progressed, or even whether he is terminally ill altogether. The strength of the state's interest in preserving life is simply not relevant to the equal protection inquiry, for it does not speak to any distinction the law might draw between the two patients "similarly circumstanced."

The implication of the Second Circuit's ruling, therefore, is that *wherever* the law permits an individual to forgo life support, equal protection demands that it also permit him to request a lethal prescription. The Second Circuit's apparent moderation is only skin deep; beneath its deceptively mild surface lies constitutional radicalism.

Consider the body of New York law implicated most directly by the ruling below. The right of competent persons to decline or discontinue life-sustaining medical intervention was first established at common law in *Schloendorf* v. *Society of New York Hospital*, 211 N.Y. 125, 129 (1914), where Judge Cardozo enunciated the basic doctrine of personal autonomy in medical decision-making: "[E]very human being of adult years and sound mind has a right to determine what shall be done with his body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *In re Storar*, 52 N.Y. 363, 376-77, *cert. denied*, 454 U.S. 858 (1981), makes clear that the common

law right of personal autonomy includes the right to refuse treatment necessary to preserve one's life. The New York courts have not limited such right to patients who are terminally ill -- certainly not to patients who are in the final stages of their terminal illness. Given the Second Circuit's rejection of any distinction between refusing life support and requesting poison, if a young patient with a good prognosis for recovery enjoys the common law right to refuse a life-saving operation, should he not also enjoy the right to a lethal prescription?

The same question will apply when a third party is legally authorized to make a decision on an incapacitated patient's behalf. Under New York common law, "the right to decline treatment is personal and...could not be exercised by a third party when the patient is unable to do so" unless there is "clear and convincing evidence" that the incapacitated patient would have refused life support. *Matter of Westchester County Medical Center*, 72 N.Y. 2d 517, 528-29 (1988). New York's legislature, however, has started moving away from the "clear and convincing evidence" standard. Most notably, in 1990, a statute was enacted empowering a duly designated health care agent to make virtually any life-and-death treatment decision on behalf of his incapacitated principal, irrespective of the principal's medical condition or prognosis. Such decisions are to be made on the basis of the principal's wishes; or, where the principal's wishes "are not reasonably known and cannot with reasonable diligence be ascertained," on the basis of the principal's "best interests." N.Y. Public Health Law § 2982 (McKinney's 1993). Indeed, the state legislature has been considering proposed new legislation developed by the New York State Task Force on Life and the Law, introduced in the 1995-96 legislative session as S.

5020 / A.6791, which would empower surrogates -- third parties appointed by the *law*, not by the *patient* -- to make decisions under certain medical circumstances to refuse life-sustaining treatment where the patient's "best interests" would be so served. The Second Circuit's equal protection analysis, it would seem, should empower such agents or third party surrogates to ask that the patient be provided with poison as well, so long as they deem it to be in the patient's "best interests."

There is yet one other noteworthy aspect of New York law: the legal obligation of an individual health care provider to carry out the instructions of patients and their duly appointed health care agents; or, if doing so would violate the provider's religious beliefs or sincerely held moral convictions, to cooperate in facilitating transfer of the patient to another medical practitioner who is prepared to carry out such wishes. N.Y. Public Health Law § 2984 (McKinney's 1993). If a doctor has religious beliefs or moral convictions that preclude him from helping the patient commit suicide, would not the Second Circuit's equal protection analysis require his cooperation in transferring the patient to a doctor who has no such qualms?

New York is not atypical in its recognition of a patient's right to decline life-sustaining interventions, either personally or through an agent or surrogate; if anything, New York's common law takes a harder line than most other states in insisting on clear and convincing evidence of an incapacitated patient's wishes. See *Cruzan* v. *Director, Missouri Dept. of Health*, *supra*, 497 U.S. at 270-77. If the Second Circuit's ruling is permitted to stand, its impact will be widespread, profound -- and, in our view, devastating.

III.

ASSIGNING DIMINISHED LEGAL PROTECTION TO A LIFE OF DIMINISHED MEDICAL QUALITY FOLLOWS DANGEROUS HISTORICAL PRECEDENT

In evaluating the state's interest in preserving and protecting a person's life, the Ninth Circuit determined that the strength of the interest depends, in part, on the person's medical condition; when the person is terminally ill and wants to die, the strength of the state interest is low. 79 F.3d at 837. Similarly, the Second Circuit concluded -- unnecessarily for its equal protection analysis, as elaborated *supra* -- that the state's interest in preserving life "lessens as the potential for life diminishes." 80 F.3d at 729. In so doing, the courts below all but nullified this Court's observation that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life." *Cruzan*, *supra*, 497 U.S. at 282.

Historical precedent confirms the wisdom of allowing society to treat human life, whatever its medical "quality", as an inherent good that deserves state protection. One need look no further than the contemporary example of the Netherlands, where many physicians have apparently engaged in nonvoluntary euthanasia despite that nation's limited authorization of only voluntary euthanasia. The New York State Task Force on Life and the Law described this "abuse" as "an inevitable byproduct of the transition from policy to practice" of permitting the taking of human life "as a 'therapeutic' alternative." *When Death Is Sought*, *supra*, at 133-34.

The history of the German euthanasia program earlier this century, under which some 200,000 mentally ill or physically disabled people were put to death by German doctors, *see generally* M. Burleigh, *Death and Deliverance: 'Euthanasia' in Germany 1900-45* (Cambridge Press 1994), also bears consideration. Burleigh cites Binding and Hoche's 1920 tract *Permission for the Destruction of Life Unworthy of Life* -- "by far the most influential contribution to the debate on euthanasia" -- as being premised on "the idea that every individual had sovereign powers to dispose of his or her own life as he or she saw fit; specifically to commit suicide." Upon that foundation the authors constructed a model that would lead to widespread medical killing in the name of mercy and social utilitarianism. *Death and Deliverance, supra* at 15-17.

In 1949, Dr. Leo Alexander, chief medical consultant to the prosecution at the Nuremberg War Crimes Tribunal, offered this trenchantly chilling analysis of the origins of the euthanasia program in Germany:

> "Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually, the sphere of those to be included in this category was enlarged to encompass

> the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick."

Alexander, *Medical Science Under Dictatorship*, 241, New England Journal of Medicine 40, 46 (1949). Dr. Alexander sounded a warning to his fellow Americans:

> "American physicians are still far from the point of thinking of killing centers, but they have arrived at a danger point of thinking, at which likelihood of full rehabilitation is considered a factor that should determine the amount of time, effort and cost to be devoted to a particular type of patient....Americans should remember that the enormity of a euthanasia movement is present in their own midst." *Id.*

We do not mean to suggest that constitutionalizing a right to assisted suicide is likely to lead to the type of moral collapse that occurred in the German medical profession earlier this century. As two commentators have noted, however, we dare not ignore the lessons of that dark era:

> "We have witnessed too much history to disregard how easily a society may disvalue the lives of the 'unproductive.' The 'angel of mercy' can become the fanatic, bringing the 'comfort' of death to some who do not

> clearly want it, then to others who 'would really be better off dead,' and finally, to classes of 'undesirable persons,' which might include the terminally ill, the permanently unconscious, the severely senile, the pleasantly senile, the retarded, the incurably or chronically ill, and perhaps, the aged. . . . In the current environment, it may well prove convenient - and all too easy - to move from recognition of an individual's 'right to die' (to us, an unfortunate phrasing in the first instance) to a climate enforcing a 'duty to die.'"

Siegler & Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support be Discontinued?*, 145 Archives of Internal Medicine 130-31 (1985). Yet another commentator issued this bleak observation:

> 'What makes the administrative mass killings so outstanding is not their numbers, their efficiency, or their cruelty, but the fact that they occurred in an epoch when nobody thought it was humanly or socially possible. Therein lies their deepest lesson. If it was possible then, why not again? What has fundamentally changed? The curtain may have gone down -- but only for the intermission." F. Wertham, *The German Euthanasia Program* 31 (1980).

In the decisions below, we detect -- ever so faintly, ever so benignly, but ever so ominously -- the rustling of the curtain once again.

CONCLUSION

The constitution can be a powerful engine of social change -- for better, and for worse. As Agudath Israel sees it, the rulings of the Ninth and Second Circuits are examples of constitutionalism at its most dangerous.

For the reasons set forth in petitioners' briefs, and the additional reasons set forth herein, Agudath Israel of America respectfully urges the Court to reverse the rulings below and clarify the limits of constitutional moral revolution.

Respectfully submitted,

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